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Editorial

Public health and the private finance initiative

Government policy has been to:

- reduce the size of the public sector through privatization and contracting out;
- involve the private sector in providing existing and new services, through the private finance initiative (PFI) and challenge funding.

(Source: *Financial statement and budget report 1997–1998*. Her Majesty's Treasury, November 1996.)

These two goals, formulated under UK Conservative administrations, have been adopted by the incoming Labour Government. The Labour Party, with its strong majority, rushed through the NHS (Private Finance) Act 1997, a piece of legislation left over from the Conservative administration. This Act, in conjunction with the NHS (Residual Liabilities) Act 1996, gave the private sector the flexibility and assurance that the public sector would be legally tied into PFI payments: the new Government resisted calls for safeguards to be written into the legislation to ensure that in the future clinical services would not be privatized and that the new PFI hospitals would have a primary duty to serve National Health Service (NHS) patients. On 10 June 1997, Alan Milburn, the Minister for Health, held a press conference to announce the go-ahead for 14 new acute hospitals to be built under the PFI. (At the Labour party conference in Brighton in October 1997, it was announced that a fifteenth scheme, at Greenwich, had been added to the list.) He also signalled his intention to continue to extend the private finance initiative to mental and community health services.

The PFI was launched in 1992 by the Treasury. The idea was that the private sector should raise the capital investment required for public sector works (including roads, bridges, schools, prisons and hospitals), in return for owning, designing, building and operating the facilities. The facilities would then be rented by the public sector or paid for through user charges (e.g. the Skye Bridge). The PFI was extended to all capital programmes in the NHS worth more than £500 000. Uncertainties surrounding the legal powers of Trusts to enter into PFI arrangements meant that contracts for building hospitals were delayed until summer 1997.

There is a commonly held view that that it does not matter who owns services or how services are delivered as long as they are free at the point of delivery. But will the NHS continue to meet the health care needs of the population in line with NHS principles under PFI procurement? Experience to date suggests not. Proper strategic planning and public health input are generally absent. The abolition of regional and district planning departments has meant that strategic service initiatives are led by departments of finance, not public health. Under the rules of the internal market, regional offices of the NHS Executive and health authorities, stripped of planning skills, have devolved service planning to NHS Trusts. With PFI, private sector consortia of builders, facilities operators and investment bankers also play a role. All are employing management consultants to do work (activity projections and bed modelling) that departments of public health and planning would previously have led. The reports produced by external consultants show that the population focus, so vital to the public health perspective, is rarely retained; and the techniques used to model need and use have rarely been tested or evaluated.[1] These shortcomings are compounded by the high degree of secrecy surrounding PFI contracts. All over the country, acute service reviews and plans for PFI hospitals are being drawn up with little information being made publicly available about the content of the contracts.

Most acute service reviews will involve private finance and will result in large NHS hospital closures and substantial bed reductions of around 20–40 per cent. Service rationalization and modernization is critical; but how are the dramatic reductions in capacity explained when the national data show little evidence of any spare capacity?[2] Against a background of rising activity, the number of NHS acute beds has increased in the last two years (1995–1996 and 1996–1997), halting several decades of decreasing bed numbers. In the absence of a population overview of activity, needs and capacity, how can the public be sure that the acute service reviews and the new PFI hospitals will meet their needs?

Advocates of PFI often claim that medical technology, the primary care led NHS and community care will reduce the need for acute hospital beds. However, evidence for this claim is not forthcoming. The question takes on particular urgency in the light of the escalating costs of PFI schemes: are bed reductions a response to changes in health care or a way of coping with problems of affordability? In almost all cases to date, the costs of PFI contracts have increased significantly between the Outline Business Case and the Full Business Case. Some of this increase can be attributed to the stronger negotiating position of the private sector consortia as NHS Trusts rush to sign up for PFI funding, but some is due to the inescapable higher cost of capital to the private sector (the public sector can always borrow more cheaply than the private sector and has no shareholders to satisfy).

As the costs of PFI schemes rise, the affordability gap (the difference between what the public sector can afford and the private sector charges) grows. The gap has been tackled in various ways, one of which has been scaling down of the size of projects and the number of beds. The NHS capital budget,

which has already been severely reduced, is being used in a number of ways to subsidize the schemes that have been given priority. Under the capital support scheme known as the smoothing mechanism nine of the first wave Trusts will receive subsidies through the first half of the PFI contract period at a total cost to the taxpayer of over £220 million.

The annual block capital allocation made by Regions to Trusts for equipment, maintenance, and new capital developments of NHS rolling stock is now used as a direct subsidy for new PFI hospitals, leaving NHS rolling stock to languish in ever-greater dilapidation. An alternative means of achieving the same end is to remove equipment from the PFI deal at a late stage without reducing the cost of the PFI contract. Equipment will then have to be paid for out of the clinical services revenue or out of the block capital for the rest of the NHS.

There is another extra cost to the public sector, in the form of the funding currently used to cover capital charges. This funding currently moves around the public sector in a circular flow without ever leaving the system, but is now to be diverted to PFI payment streams, where of course it is lost to the public purse forever.

The NHS will also have to pay for the decrease in capacity that characterizes new PFI schemes. Most PFI acute hospitals assume both reductions in activity and capacity, and that patient care will be transferred to primary, community and social services settings. However, the extra resources required to meet need will not follow. Very few acute service reviews have parallel detailed plans for community and primary health services.

Health authorities and fundholders do not have a statutory right to see the contracts between Trusts and the PFI consortia. As payment streams and the payment mechanisms are deemed commercially sensitive, the implications for other services are not known. Until the financial strategies, the contracts, and the Outline and Full Business Cases are made publicly available the public cannot be assured that the NHS is safe in private sector hands.

Both governments have claimed that the great virtues of PFI lies in the transfer of risk. It is difficult to understand just how much risk the private sector is assuming when its shareholders are demanding an annual rate of return of 10–17 per cent and the NHS is locked into 30–60 year contracts which are effectively ring-fenced. Moreover, the transfer of risk to the private sector does not offset the higher costs of private capital: it is an additional cost, as the private sector expects to be rewarded for taking on risk.

Health authorities, NHS Trusts and consortia involved in PFI schemes for new hospitals believe that reductions in acute beds capacity can be met by a radical transfer of care to the primary, community and social care sectors. The Government insists that control of clinical care under PFI schemes will remain in the public sector and that there is no threat to a service free at the point of delivery on the basis of need. Nevertheless, the current direction of NHS policy on the PFI must cause disquiet. If cuts in acute hospital capacity lead to further rationing of elective care with lengthening waiting lists, private care will be an increasingly attractive option for those able to pay. The consortia running the new PFI hospitals will have no restrictions on their commercial operations: they will be free to sell insurance policies, long-term care and other health service products such as rehabilitation and convalescence (*Hansard*, column 307, 7 July 1997). The progressive downsizing of the acute hospital and community health sectors may lead to piecemeal fragmentation of the NHS, reshaping it as an emergency safety-net service.

The pursuit of public health must include preserving the strengths of the NHS. Open debate on the implications of the PFI for the NHS is urgently required. Not to do so will be to the detriment not only of the population we serve but of the specialty of public health. Markets have no need of public health advocates.

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